No. 2
5-42
17-39
X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 20 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16944

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2048

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Willows Hospital-2929 Main St O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 hrs (Specify whether years, months or days)
In this community same

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 2929 Main St
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country O

3. (a) PRINT FULL NAME Arthur Burgstahler
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced babe
6. (b) Name of husband or wife none
6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased May 8 1944 (Month) (Day) (Year)
8. AGE: Years -- Months -- Days -- If less than one day 13 hr. ---- min.
9. Birthplace Kansas City (City, town, or county) Mo (State or foreign country)
10. Usual occupation none
11. Industry or business none
MOTHER FATHER
12. Name unknown
13. Birthplace " " (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Matty Burgstahler.
15. Birthplace Fessenden No Dakota (City, town, or county) (State or foreign country)
16. (a) Informant A.U.Dysart R.N.
(b) Address 2929 Main St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May IIth 1944 (Month) (Day) (Year)
(c) Place: burial or cremation Green Lawn Cem Eylar Funeral Home
18. (a) Signature of funeral director 1800 Linwood Blvd
(b) Address
19. (a) 5-11-44 (Date received local registrar) (b) N. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 9 th year 1944 hour minute 8:45 A M.
21. I hereby certify that I attended the deceased from May 8, 1944, to May 9, 1944; that I last saw him alive on May 9, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death 1. Atelectasis	
premature twin # 1	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature H. L. Dwyer (M. D. or other)
Address 315 Alameda Rd. Date signed 5-13-44

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ~~was~~ not embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Chas. Wilks

Licensed Embalmer No. 2644

P. O. Address 1800 Linwood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.